



ST. PAUL ELECTRICAL WORKERS HEALTH PLAN

1330 Conway Street • Suite 130
St. Paul, Minnesota 55106
(952)851-5949



Dear Member,

Please fill out the enclosed PHI form allowing us to speak to whomever you designate under section 1. Without this form, we cannot give out any information pertaining to your medical coverage (i.e. deductibles, claims, etc.). This form will need to be filled out by anyone over the age of 18.

How to fill out section 2 of this form – YOU MUST CHOOSE ONLY 1 OPTION:

Information held by the Plan concerning my eligibility, claims decisions and payments.

- By choosing the first option, **the most common option chosen**, you are allowing us to speak to who you designated in section 1 on behalf of ALL of your Plan information.

Medical information held by the Plan from the following doctor, clinic, or hospital: (list specifics below)

- By choosing the second option, you will need to list **EVERY** doctor, clinic, etc. that we are allowed to speak to, on your behalf, to who you designated in section 1. We can only speak to your designee(s) regarding these specific doctors, clinics, etc.

Other. (list specifics below)

- This option would be chosen for the following example:
Parents who do not live together – allows access to non-member parent regarding children(s) information only

If you have any questions regarding this form, please feel free to contact our office at 952-851-5949. The benefits office hours are Monday through Thursday, 7:30 AM to 4:30 PM and Friday 7:30 AM to 3:30 PM.

Please return this form in the enclosed envelope, fax 651-776-9973 or email to spewbenefits@wilson-mcshane.com.

Thank you,
St. Paul Electrical Worker's Benefit Office

St. Paul Electrical Workers Health Plan

Authorization for Release of Protected Health Information (PHI) By the Fund

You **MUST** complete all of the information requested in this form for your authorization to be valid.

I authorize the Plan the use and disclosure of my Protected Health Information (PHI) as described in this authorization. I understand the Plan may not condition my treatment, payment, enrollment or eligibility for benefits on whether or not I give the authorization listed in this form.

(1) **The Plan can release PHI to:** The Plan, its agents or subcontractors ("Business Associates") is authorized to release the PHI described below to the following person, class of persons, or organization:

- My spouse _____ My Union _____
 My parents _____ My Employer _____
 Other (Print Name or Position): _____

(2) **The information that may be used or released is:**

- Information held by the Plan concerning my eligibility, claims decisions and payments.
 Medical information held by the Plan from the **following doctor, clinic, or hospital:**

- Other. Please specify below.

(3) **Right to revoke:** I understand that I have the right to revoke this authorization at any time by notifying the Plan's Contact Person in writing at the address listed at the bottom of this Form. I understand that the revocation is only in effect after it is received and logged by the Plan. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(4) **Re-Release of Information:** I understand that after this information is released, federal law might not protect it and the recipient might re-release it I also understand and agree to hold the Plan and any of its agents and subcontractors harmless if the information is re-released.

(5) **Copy:** I understand that the Plan will give me a copy of this authorization

(6) **THE AUTHORIZATION WILL EXPIRE ON THE DATE ON WHICH YOUR ELIGIBILITY UNDER THE PLAN TERMINATES UNLESS YOU SPECIFY ANOTHER DATE OR TERMINATION EVENT BELOW.**

- Other: _____

Your Signature: _____ Date: _____

Print Your Name: _____

Member Name: _____

Please Print

Member Address: _____ SSN or ID #: _____

Mail or Fax Completed Forms to the Fund Administrator:

1330 Conway Street, Suite 130
St. Paul, MN 55106

Fax: (651) 776-9973